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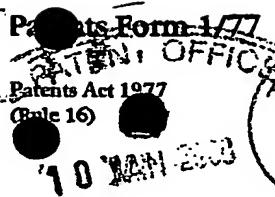
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By virtue of a direction given under Section 30 of the Patents Act 1977, the application is proceeding in the name of

**HEALTH PROTECTION AGENCY,
Porton Down,
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Incorporated in the United Kingdom,

[ADP No. 08638108001]



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2. Patent application number

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10 JAN 2003

3. Full name, address and postcode of the or of each applicant (underline all surnames)

Microbiological Research Authority
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13/03

Patents ADP number (if you know it)

If the applicant is a corporate body, give the country/state of its incorporation

SECTION 30 (1977 ACT) APPLICATION FILED

UK

65-66160002

4. Title of the invention

Phage Biofilms

5. Name of your agent (if you have one)

"Address for service" in the United Kingdom to which all correspondence should be sent (including the postcode)

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Description

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Claim(s)

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Abstract

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10 January 2003

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DUPLICATE

-1-

Phage Biofilms

The present invention concerns compositions for treating bacterial biofilms using bacteriophages, modified bacteriophages, and associated methods and uses of
5 bacteriophages.

There is an urgent need in the near future to develop alternative anti-microbials to replace antibiotics for treating a whole spectrum of bacterial diseases. Action is needed due to an alarming increase of antibiotic resistance that poses a very real
10 threat to modern medicine. Intermittent treatment and the re-emergence of infection tends to create selective pressure towards producing resistant microbial strains, and the nature of hospital environments and the sheer number of routine operations make the spread of infection more hazardous. Additionally, the ease and frequency of international travel assists in the spread of resistant bacteria throughout the world.
15

Many pathogenic microorganisms reside within biofilms, which biofilms cause additional problems when designing new anti-microbial agents. In this regard, bacteria and fungi growing as a biofilm rather than in free-floating (ie. planktonic forms) tend to be particularly resistant to anti-microbial agents and to be particularly
20 difficult for the host immune system to render an appropriate response.

Examples of biofilm-associated microbial infections include infections of:- oral soft tissues, teeth and dental implants; middle ear; gastrointestinal tract; urogenital tract; airway/lung tissue; eye; urinary tract prostheses; peritoneal membrane and peritoneal
25 dialysis catheters, indwelling catheters for hemodialysis and for chronic administration of chemotherapeutic agents (Hickman catheters); cardiac implants such as pacemakers, prosthetic heart valves, ventricular assist devices, and synthetic vascular grafts and stents; prostheses, internal fixation devices, and percutaneous sutures; and tracheal and ventilator tubing. Both indwelling and
30 subcutaneous biomedical implants or devices are potential sites for microbial infections and represent important targets for the control of infection, inflammation, and the immune response. Biomedical systems such as blood oxygenators, tracheal

lavage, dental water units, and dialyzers are also susceptible to bacterial contamination and biofilm formation.

A biofilm is an accumulation of microorganisms embedded in a matrix of
5 polysaccharide. Biofilms may form on solid biological or non-biological surfaces and are medically important, accounting for over 80 percent of microbial infections in the body.

10 Virulence and pathogenicity of microorganisms is often enhanced when growing as a biofilm, and new strategies are therefore required to control biofilm formation and development.

15 Biofilms are difficult to treat with anti-microbials and bacterial resistance to antibiotics is enhanced up to 1000-fold over the level observed when grown under planktonic conditions.

Biofilms increase the opportunity for gene transfer between bacteria and may be significant for the transfer of resistance genes to associated susceptible bacteria. Gene transfer can convert a previously avirulent strain into a virulent pathogen.

20 New, and more virulent microbial phenotypes may be expressed when growing within a biofilm.

25 Bacteria embedded within biofilms are resistant to both immunological and non-specific defence mechanisms of the body. Contact with a solid surface induces the expression of a bacterial enzyme, which catalyses the formation of exopolysaccharides that promote colonisation and protection.

30 Immune responses are only directed towards those antigens on the outer surface of the biofilm. Antibodies and other serum or salivary proteins may fail to penetrate into the biofilm. Cells within the biofilm remain hidden from antibody and complement factor recognition, and thus from subsequent white blood cell phagocytosis. The

presence of biofilms can modulate cytokine synthesis, and can interrupt production of antibodies via synthesis of superantigens. Phagocytes are unable to effectively engulf a bacterium growing within a complex polysaccharide matrix attached to a solid surface. This may result in phagocytes releasing large amounts of pro-
5 inflammatory enzymes and cytokines, leading to inflammation and destruction of nearby tissues.

As bacterial cell density within a biofilm increases, the bacteria may communicate with each other. This can lead to the secretion of low molecular weight molecules
10 that signal when the population has reached a critical threshold. This process, called quorum sensing, is responsible for the expression of virulence factors. For example, *Pseudomonas aeruginosa* produces destructive proteases when the number of these bacteria reaches a high enough density in the airway biofilms of cystic fibrosis (CF) patients.

15 Accordingly, alternative curative and prophylactic approaches for tackling microbial infections within a biofilm are required.

Bacteriophage based therapies have been considered in the past for the treatment
20 of free-floating (ie. planktonic) microbial infections.

However, following the discovery of antibiotics, phage therapy was eclipsed in the 1940s, although extensive clinical research continued in Eastern Europe. In Russia and Georgia, phage are currently produced and marketed by a number of companies
25 for the treatment of enteric disorders, bladder infections and post-operative infections.

In Britain and the United States, there has been renewed interest in the application of phage therapy since the 1980's. For example, the successful treatment of
30 domestic animals with *E. coli* infections has been reported by Smith and Huggins (1983; 1987), and by Barrow *et al.* (1998). Phage have been used in treating burns infected with *P. aeruginosa*. Soothill *et al* (1994) have demonstrated that skin-graft

rejection could be prevented in a guinea pig model by prior treatment with *Pseudomonas* phage, and in an earlier study (Soothill et al 1992) have demonstrated phage mediated protection of mice from a systemic *Pseudomonas* infection. Biswas et al. (2002) have recently reported the successful bacteriophage mediated rescue
5 of bacteremic mice infected with vancomycin resistant *Enterococcus faecium*.

However, none of the above art addresses the treatment of biofilm infections, which account for many current clinical infections, and their associated medical conditions (see Table 1).
10

TABLE 1

Infections of disease	Common biofilm bacterial species
Nosocomial infections: ICU pneumonia Sutures Exit sites Arteriovenous shunts Schleral buckles Contact lens Urinary catheter-cystitis Peritoneal dialysis (CAPD) peritonitis IUDs Endotracheal tubes Hickman catheters Central venous catheters Mechanical heart valves Vascular grafts Biliary stent blockage Orthopedic devices Penile prostheses	Gram-negative rods <i>Staphylococcus epidermidis</i> and <i>Staphylococcus aureus</i> <i>S. epidermidis</i> and <i>S. aureus</i> <i>S. epidermidis</i> and <i>S. aureus</i> Gram-positive cocci <i>Pseudomonas aeruginosa</i> and Gram-positive cocci <i>Escherichia coli</i> and other Gram-negative rods A variety of bacteria and fungi <i>Actinomyces israelii</i> and many others A variety of bacteria and fungi <i>S. epidermidis</i> and <i>Candida albicans</i> <i>S. epidermidis</i> and others <i>S. aureus</i> and <i>S. epidermidis</i> Gram-positive cocci A variety of enteric bacteria and fungi <i>S. aureus</i> and <i>S. epidermidis</i> <i>S. aureus</i> and <i>S. epidermidis</i>
Dental caries Periodontitis Otitis media	Acidogenic Gram-positive cocci (eg. <i>Streptococcus</i>)
Musculoskeletal infections Necrotizing fasciitis Biliary tract infection Osteomyelitis	Gram-negative anaerobic oral bacteria Non-typable strains of <i>Haemophilus influenzae</i>
Bacterial prostatitis Native valve endocarditis Cystic fibrosis pneumonia	Gram-positive cocci (eg. <i>staphylococci</i>) Group A streptococci Enteric bacteria (eg. <i>E. coli</i>) Various bacterial and fungal species - often mixed <i>E. coli</i> and other Gram-negative bacteria Viridans group streptococci <i>P. aeruginosa</i> and <i>Burkholderia cepacia</i>

* Abbreviations: CAPD, continuous ambulatory peritoneal dialysis; ICU, intensive care unit; IUD, intrauterine device.

One of the first studies to examine the interaction of bacteriophage with biofilms was reported by Doolittle *et al.* (1995, 1996). Biofilms of *E. coli* strains 3000 XIII developed on the surfaces of polyvinylchloride coupons in a modified Robbins device were infected and lysed using bacteriophage T4D. Similar studies with phage E79 5 infecting *Pseudomonas aeruginosa* indicated phage were infecting the surface organisms but access to the cells deep in the biofilm was restricted. Temperature and nutrient concentration did not appear to affect susceptibility, but low temperature and low nutrients did prolong the time for lysis to occur and slowed the spread of infection within the biofilm. The *E. coli* biofilms were relatively thin (15-30 μ m) 10 compared to the *P. aeruginosa* biofilm (150 μ m).

Sutherland *et al.* (1999) reported that, during the early stages of biofilm development, bacteriophage have an effect on biofilm development. Surface decontamination of stainless steel and polypropylene contaminated with *Listeria monocytogenes* was 15 evaluated using Listeriaphage. Phage suspensions at concentrations up to 3.5×10^8 pfu per ml were found to have an effect in reducing the bacterial count (comparable activity with 20 ppm solution of a quaternary ammonium compound, QUATAL (Roy *et al.* 1993)).

20 Bacteriophage SF153b, isolated from sewage and able to infect the biofilm-forming bacterium *Enterobacter agglomerans* 53b, was shown to possess a depolymerase specific for the exopolysaccharide of strain 53b (Hughes *et al.*, 1998). Using a Robbins device, the phage was shown to disrupt the exopolysaccharide (EPS) of a mono-species biofilm and to infect the cells.

25

Hanlon *et al.* (2001) have recently demonstrated the ability of *P. aeruginosa* phage to diffuse through alginate gels at alginate concentrations up to 8% (wt/vol), and to bring about a 2-log reduction in the cell numbers in 20-day-old biofilms of *P. aeruginosa*. Samples of commercial alginate and purified cystic fibrosis (CF) alginate 30 were incubated with 2×10^8 purified phage per ml for 24 h at 37°C, and the viscosity of phage-treated samples were reduced by up to 40% compared to those of controls incubated in the absence of phage. The alginate treated with phage had a lower

molecular weight than untreated alginate, and the evidence suggested that the reduction in alginate viscosity was brought about by enzymic degradation derived from the bacterial host itself.

5 Of the infections listed in Table 1, one of the most problematic infections to treat is that of cystic fibrosis pneumonia.

Most cystic fibrosis (CF) patients suffer from recurrent and chronic end-bronchial *Pseudomonas aeruginosa* infections. Intervention strategies include eliminating cross

10 infection, and early aggressive antibiotic treatment. An inflammatory response occurs resulting in a shift of the organism's phenotype from non-mucoid to a mucoid phenotype. This alginate producing phenotype then grows as an endo-bronchial biofilm, which is impossible to eradicate through antibiotic therapy.

15 There is therefore a need for alternative approaches for the treatment of infectious biofilms, preferably those associated with cystic fibrosis.

According to a first aspect, the present invention provides a composition comprising a bacteriophage and one or more polysaccharide depolymerase or lyase enzymes,

20 which bacteriophage can penetrate biofilms and infect biofilm-associated bacteria to cause a reduction in bacterial numbers, preferably a reduction of between about 1 and 3 logs of bacterial viable counts. In a preferred embodiment, the bacteriophage encodes said one or more polysaccharide depolymerase or lyase enzymes. Also provided are modified bacteriophages, methods of creating modified bacteriophages, 25 compositions for treating biofilms comprising bacteriophages, and methods for treating biofilms using the bacteriophages and compositions of the invention.

The following advantages are provided by the present invention, which employs the use of a bacteriophage to target and destroy (or protect against the formation of) 30 infectious biofilms.

Phage are self-replicating and self-limiting and may be delivered by aerosol to the

lungs. The self-replicating property is an advantage when patient compliance towards regular drug therapy is poor.

5 Phage may be highly specific in their destruction of their targets and unlike antibiotics, they do not interfere with natural flora.

Phages are easy to produce and are a cost-effective form of therapy.

10 Phage can be formulated as a unique cocktail or in combination with other antimicrobials in order to destroy multiple strains of *Ps. aeruginosa* and other organisms, which other organisms contribute significantly towards morbidity and mortality.

15 Phage may be used to treat immuno-compromised individuals or patients that have an allergy to antibiotics.

20 Phage can be stored for very long periods with no obvious loss of activity.

25 The therapeutic use of phage has been widely used in Eastern Europe for over 60 years with no reported significant adverse effects.

The bacteriophage preferably targets one or more of the bacteria listed in Table 1.

30 Particularly preferred bacterial targets include one or more of:- *Staphylococcus aureus*; *Haemophilis influenzae*; *Pseudomonas aeruginosa*; *Burkholderia cepacia*; *Streptococcus pneumoniae*; *Stenotrophomonas maltophilia*; *Alcaligenes xylosoxidans*; *non-tuberculous mycobacteria*; *Mycobacterium bovis*; *Mycobacterium smegmatis*; *Mycobacterium tuberculosis*; *Burkholderia multivorans*; *Burkholderia stabilis*; and *Burkholderia vietnemesis*. In terms of simple nomenclature, the bacteriophages are usually identified by reference to the bacteria that they infect. Thus, a bacteriophage that infects a mycobacterium may be referred to as a

mycobacteriophage.

The present invention is preferably concerned with the treatment of biofilm-associated opportunistic infections, and particularly with the treatment of such 5 infections in lung biofilms (eg. those associated with CF patients). Thus, the highly preferred bacterial targets of the present invention are *Pseudomonas* sp. and *Burkholderia* sp., especially *Ps. aeruginosa* and *B. cepacia*.

Preferred bacteriophage for use against the above bacterial targets have a high 10 affinity for the bacterial target strain, high burst size and encode an alginate lyase. Where the bacterial target is *Ps. aeruginosa*, suitable bacteriophage include Φ GH4, Φ GH6, Φ GH13 and Φ GH14.

Thus, the invention provides a composition for treating a bacterial biofilm comprising 15 a bacteriophage, and a first polysaccharide depolymerase or lyase enzyme (eg. an alginate lyase). The first polysaccharide depolymerase/lyase may be absorbed onto the surface of said bacteriophage. The composition may further comprise an antibiotic, a second (preferably different) polysaccharide depolymerase or lyase, optionally adsorbed onto the surface of the bacteriophage, a DNase or a polypeptide 20 defensin. The bacteriophage may optionally encode said first, or more than one polysaccharide depolymerase or lyase, said DNase, said antibiotic and/or said defensin.

The biofilm matrix typically comprises a high proportion of water (see Table 2), 25 although this would depend on the specific biofilm system examined. Apart from water and microbial cells, the biofilm matrix is a complex of absorbed nutrients and metabolites, products from cell lysis, particulate material from the immediately surrounding area and secreted polymers. All major classes of macromolecules, protein, polysaccharides, DNA and RNA can be present in addition to peptidoglycan, 30 lipids and other cell components.

Table 2 - Typical Range of Biofilm Matrix Composition

	Component	% of matrix
5	Water	up to 97%
	Microbial cells	2-5%
	Polysaccharides	1-2%
	Proteins	< 1-2%
	DNA and RNA	< 1-2%
10	Ions (bound and free)	1%

The production of exopolysaccharides (EPS) is essential to the development of the architecture of the biofilm. It provides a framework into which microbial cells are inserted, and may also serve as a nutrient source for sessile cells.

15 Alginate is the major extracellular product of mucoid strains of *Ps. aeruginosa* that chronically colonise the cystic fibrosis (CF) pulmonary cavity. The alginate glycocalyx acts as a barrier for *Ps. aeruginosa* sessile cells to antimicrobial agents and host defences, and thus the mucoid form of *Ps. aeruginosa* is much more difficult to treat and is invariably associated with a poor prognosis for CF patients. Novel methods of 20 eradicating this mucoid form of the organism are therefore essential for successful treatment of these chronic infections.

Ps. aeruginosa produced alginate is a linear polysaccharide comprised of 1-4 linked β -D-mannuronic acid (M) (O-acetyl substitution on 2 and/or 3 position) and α -L-guluronic acid (G) monomers, which can either be arranged in homopolymeric (poly-guluronate GGGG, poly-mannuronate MMMM) or heteropolymeric (random sequences MGMG) regions.

30 Alginate lyases are classified based on their dominant cleaving action on M rich or G rich alginates. As all three structures (i.e. the hetero and both homopolymeric structures) may be present within a single alginate molecule, the preferred alginate lyase of the present invention for *Ps. aeruginosa* biofilm treatment has high affinities for at least one of, preferably both M and G rich regions. The lyase may be encoded by the phage of the present invention, and/or may be exogenous with respect to the

phage. It is also beneficial for the lyase to exhibit endo-cleaving activity (i.e. it can break up long linear alginate chains within their complex blocks of monomeric units, as opposed to exolytic activity in which monomers are removed from the ends of the polymer), thus breaking down the viscous long chained polymer into more aqueous
5 oligosaccharide shorter chain products.

In use of the present invention, a polysaccharide depolymerase or lyase enzyme is preferably selected such that it is capable of breaking down a component of the biofilm of interest. It is particularly preferred that the enzyme is selected such that
10 it is capable of breaking down a component of the biofilm, which component (eg. a polysaccharide) is produced by a bacterium associated with (eg. residing within) the biofilm of interest.

The presence of a DNase may help to break down DNA from dead patient host cells
15 (eg. lung epithelial cells) within a biofilm, and may help to dissolve mucus components associated with a biofilm.

Defensins are a group of gene-encoded anti-microbial peptides that have been identified from a diverse range of organisms, such as vertebrates, invertebrates,
20 plants and bacteria. In mammals, defensins are part of the innate host defence mechanism and are present in phagocytic cells and epithelial cells. They show a potent activity towards microorganisms, and are particularly useful for targeting antibiotic resistant bacteria [see Hancock, R.E. and Chapple, D.S. (1999) Antimicrobial Agents and Chemotherapy, vol. 43, No. 6, pp. 1317-1323].
25

By way of example, the following defensins are suitable for use in the present invention:-

gramicidin S; bacitracin; polymyxin B; α -defensin (eg. rabbit source); β -defensin (eg. human source); tachyplesin (eg. crab source); bactenecin (eg. cattle source);
30 cecropin A (eg. silk moth source); indolicidin (eg. cattle source); and nisin (eg. bacterial source). The term "defensin" embraces synthetic peptides having antimicrobial activity, which may be employed in the present invention. Examples of such synthetic peptides are provided in the above mentioned review by Hancock

(1999). Of particular mention is the polymyxin family of antimicrobial polypeptides, especially polymyxin E (ie. Colistin) and polymyxin B.

Defensins (eg. polymyxins) are bactericidal in preferred concentrations of up to 8 μ g ml⁻¹, more preferably 1-5 μ g ml⁻¹.

Preferred defensins are those that attach to bacterial cell membranes (especially those rich in phosphatidylethanolamine), and disrupt the osmotic properties and transport mechanisms of the membrane.

10

Further examples of defensins, which are suitable for use in the present invention, are provided by US 5,242,902, US 5,641,497, WO89/11291, WO94/21672, and WO95/32287.

15 Antibiotics are well known in the art, and may be employed in the present invention. Of particular mention is the aminoglycoside family of antibiotics, which were originally obtained from *Streptomyces* species, and in particular tobramycin. Antibiotics (eg. tobramycin) are bactericidal in preferred concentrations of up to 8 μ g ml⁻¹, more preferably 1-5 μ g ml⁻¹. A typical antibiotic dosage regime according to the present
20 invention for treating CF patients is the administration of 80mg of antibiotic, preferably tobramycin, by nebulisation twice a day. As there is little adsorption from the mucosa, serum levels of tobramycin are unmeasurable.

According to one embodiment of the invention, the antibiotic acts by inhibition of
25 ribosomal protein synthesis. Preferred antibiotics according to this embodiment are members of the aminoglycoside family. A particularly preferred antibiotic according to this embodiment is tobramycin.

Another preferred class of antibiotics is the Polymyxin family, particularly Polymyxins
30 E (Colistin) and B. Colistin is bactericidal for Gram-negative bacilli including *Pseudomonas* spp. in preferred concentrations of up to 8 μ g ml⁻¹, more preferably 1-5 μ g ml⁻¹. Polymyxins, such as Colistin, are preferably used as topical agents due to poor absorption of these antibiotics from the gut. It is preferred that Colistin is

administered as of Colistin sulphate, which is the stable water-soluble form. A typical dosage regime for CF patients is the administration of 2 mega units of Colistin by nebulisation twice a day. As there is little adsorption from the mucosa, serum levels of Colistin are unmeasurable.

5

According to one embodiment of the invention, the preferred antibiotic acts by attachment to bacterial cell membranes rich in phosphatidylethanolamine and disruption of the osmotic properties and transport mechanisms of the membrane. Preferred antibiotics according to this embodiment are members of the Polymyxin family, particularly Colistin.

10

Further antibiotics of particular mention are ciprofloxacin (preferably administered orally) and ceftazidime (preferably administered intravenously).

15

The bacteriophage may be a wide spectrum phage. For example, it may target several different species within a given genus, or may even target bacteria within different genera. Alternatively, the bacteriophage may be a narrow spectrum phage. For example, it may be specific to a given bacterial genus, species, or strain. The bacteriophage is capable of infecting a bacterium present in the biofilm of interest.

20

In a most preferred embodiment the invention provides a composition for treating a lung biofilm in a CF patient, preferably a biofilm comprising *Pseudomonas aeruginosa* and/or *Burkholderia cepacia*. The composition according to this embodiment preferably comprises a bacteriophage that encodes a polysaccharide depolymerase or lyase, preferably an alginate lyase enzyme. Alternatively, the enzyme may be provided exogenously.

25

A preferred bacteriophage according to the present invention is a bacteriophage selected from the GH group of phage such as GH4, GH6, GH13, GH14 (ECACC accession numbers 02121203, 02121202, 02121201, and 02121204 respectively, deposited by the applicant in ECACC on 12 December 2002). A particularly preferred phage is bacteriophage ΦGH4.

Also provided is use of the composition in manufacture of a medicament for treatment of a bacterial biofilm. A preferred target is a lung biofilm in a CF patient.

Preferably the medicament is administered in more than one dose, more preferably

5 in at least 3 separate doses (eg. per day). It is also preferred that administration of the medicament results in a reduction in the bacterial cell count of the biofilm of at least one log, preferably at least three logs.

According to a second aspect, the invention provides a bacteriophage comprising a

10 heterologous gene encoding a polysaccharide depolymerase or lyase enzyme (eg. an alginate lyase). Preferably, the bacteriophage specifically infects a bacterial species or strain present in the biofilm. The polysaccharide depolymerase or lyase encoded by the modified bacteriophage should preferably degrade a specific polysaccharide produced by a bacterial species or strain present in the biofilm. In a
15 particularly preferred embodiment, the biofilm comprises *Ps. aeruginosa* and/or *B. cepia*. In another preferred embodiment, the bacteriophage encodes an alginate lyase enzyme.

The bacteriophage may optionally comprise more than one hetererologous gene

20 encoding a polysaccharide depolymerase or lyase (eg. an alginate lyase). Said enzymes are preferably different, and therefore degrade different exopolysaccharide (EPS) components of a biofilm. The terms EPS and polysaccharide are used interchangeably in the biofilm context of the present invention. The bacteriophage may also encode a DNase, antibiotic, and/or defensin.

25

The modified bacteriophage, like the composition of the first aspect, may be used to treat biofilms such as those resulting from opportunistic bacterial infections. For example, chronic lung infections in CF patients may be treated. The bacteriophage may be optionally used as part of a composition also comprising an antibiotic, a
30 second (preferably different) polysaccharide depolymerase or lyase enzyme (eg. an alginate lyase), a DNase or a polypeptide defensin.

In one embodiment, the composition may comprise a first and second bacteriophage, wherein the first bacteriophage comprises a gene encoding a first polysaccharide depolymerase or lyase enzyme, and the second bacteriophage comprises a gene encoding a second polysaccharide depolymerase or lyase enzyme, and wherein the

5 first and second polysaccharide depolymerase or lyase enzymes are not the same.

In a related embodiment, which applies to both the first and second aspects of the present invention, a cocktail of several different bacteriophages may be employed in combination with two or more different depolymerases/lyases (eg. an alginic
10 lyase). The depolymerases/lyases may be provided exogenously or may be encoded by one or more of the bacteriophage. Not all bacteriophage employed in a composition of the present invention need encode a polysaccharide depolymerase or lyase. Such bacteriophage may possess, for example, enhanced bacteriolytic activity *vis-a-vis* other bacteriophage with respect to biofilm-associated bacteria.

15 Other bacteriophage suitable for treatment of *Ps.aeruginosa* biofilms according to any embodiment of the present invention are publicly available from the American Type Culture Collection and include bacteriophage having accession numbers ATCC 12055-B1, ATCC 12055-B2, ATCC 12055-B3, ATCC 14205-B1, ATCC 14206-B1,
20 ATCC 14207-B1, ATCC 14209-B1, ATCC 14210-B1, ATCC 14211-B1, ATCC 14212-B1, ATCC 14213-B1, ATCC 14214-B1, ATCC 15692-B2, ATCC 15692-B3, ATCC 25102-B1, ATCC BAA-26-B1, ATCC BAA-27-B1, ATCC BAA-28-B1, ATCC BAA-28-B2, ATCC BAA-29-B1, ATCC BAA-30-B1, ATCC BAA-31-B1, ATCC BAA-47-B1, ATCC BAA-79-B1,
25 ATCC BAA-81-B1, and ATCC BAA-81-B2.

The invention also provides a method of making a modified bacteriophage comprising:

30 a) preparing a biofilm sample;
 b) identifying an infecting bacterial species or strain within the biofilm;
 c) selecting at least one gene encoding a polysaccharide depolymerase or lyase enzyme that degrades a polysaccharide within said biofilm;

- d) selecting a bacteriophage that is capable of infecting the bacterial species or strain identified in step b); and
- e) introducing at least one of the genes selected in step c) into the bacteriophage DNA.

5

In a preferred embodiment, the biofilm sample of step a) is prepared by obtaining a clinical sample from a patient having a biofilm infection. The sample is preferably taken from the lung of an infected patient, and most preferably from the lung of a CF patient having a lung biofilm infection.

10

In a preferred embodiment the bacteriophage is specific for the bacterial species or strain identified in step b).

15 In one embodiment the polysaccharide depolymerase or lyase enzyme recited in step c) may be selected by use of a bank of specific enzymes, which may be tested individually on the biofilm for degradative activity. Thereafter, biofilm degradation may be confirmed by turbimetric analysis, viscometry, or chromatographic analysis.

20 Said bacteriophage may be employed in the treatment of a biofilm-associated microbial infection as described in the preceding aspects of the present invention.

The modified bacteriophage may be further modified to encode a second depolymerase, an antibiotic, a DNase and/or a defensin as described above for the first or second aspects of the present invention.

25

It is preferred that the efficacy of the modified bacteriophage be tested *in vitro* prior to use against infections in a clinical context.

30 According to further aspect the invention provides a method of identifying a bacteriophage for use in treatment of a biofilm-associated microbial infection, which method comprises:-

- a) preparing a biofilm sample;
- b) identifying an infecting bacterial species or strain within the biofilm;

- c) identifying a bacteriophage that is capable of infecting said bacterial species or strain, and which encodes a polysaccharide depolymerase or lyase that degrades a polysaccharide within said biofilm;
- d) optionally testing the efficacy of the selected bacteriophage against a sample of the biofilm *in vitro*; and
- e) if necessary, repeating steps a) to e).

5 In one embodiment, step b) may optionally include identifying a polysaccharide component within the biofilm or a polysaccharide produced by the microorganisms 10 of the biofilm.

The identified bacteriophage may be modified according to the first or second aspects of the invention so that it encodes a further polysaccharide depolymerase, an antibiotic, a DNase, and/or a defensin.

15 Said bacteriophage may be employed in the treatment of a biofilm-associated microbial infection as described in the preceding aspects of the present invention.

The present invention provides a method of treating biofilm-associated infections.

20 In operation, the method involves administration of at least one dose, preferably at least three doses, of bacteriophage (including a first either endogenous or exogenous polysaccharide depolymerase/lyase) to the site of infection. Administration may be by several methods, a preferred method being aerosol delivery.

25 According to a preferred aerosol delivery embodiment, the particle size in the aerosol is between 100 μm and 1 μm . In more detail, a particle size of approximately 60 μm targets biofilms in the upper respiratory tract, whereas a particle size of 2-4 μm targets biofilms at or near the alveoli. Thus, the aerosol may have a broad delivery 30 range (ie. contain particles of 1-100 μm), or may have a narrow delivery range (eg. 2-20 μm for targeting the lower airways, or 40-100 μm for targeting the upper airways).

In use, the phage is preferably present at a concentration of 10^7 - 10^{11} plaque forming units (pfu) per ml, more preferably 10^8 - 10^9 pfu per ml.

The method provides for a dramatic reduction in the numbers of bacteria in the

5 biofilm. A reduction of up to three logs can be achieved with phage treatment alone, but may be further enhanced by administration of a second polysaccharide depolymerase/lyase, an antibiotic, a DNase and/or a defensin, either at the same time, prior to, or subsequently to administration of the bacteriophage.

10 In one embodiment, the repeated, combined use of phage plus an antimicrobial agent (eg. an antibiotic) to treat CF patients helps to prevent the re-colonisation of parts of the lung by cells that have been released from the biofilm.

The above prophylactic or curative method is particularly suitable for treatment of

15 biofilm infections of the lung and gastrointestinal tract, and biofilms present on medical devices such as catheters, intra-vascular devices, prosthetic devices and dental implants. In particular, biofilm disruption according to the present invention enables access of antimicrobial agents (eg. antibiotics) and other phage to microorganisms residing deep within said biofilm. Such access is not otherwise

20 possible with the isolated use of an antimicrobial agent.

The invention is illustrated by the following drawings, in which:

Figure 1: shows growth dynamics of control and bacteriophage infected *Ps. aeruginosa* biofilm cells in which the biofilm was infected with 1 dose of bacteriophage (10 ml of 10^9 plaque forming units per ml {pfu ml⁻¹});

Figure 2: shows growth dynamics of control and bacteriophage infected *Ps. aeruginosa* biofilm and planktonic cells in which the biofilm was infected with 4 doses of bacteriophage (10 ml of 10^9 pfu ml⁻¹ every six hours for the first 18 h of experiment);

Figure 3: shows growth dynamics of control and tobramycin dosed *Ps. aeruginosa* biofilm and planktonic cells in which the biofilm was infected with 4 doses of tobramycin at the minimal inhibition concentration (4 mg L^{-1}); and

5 Figure 4: shows growth dynamics of control and bacteriophage/tobramycin dosed *Ps. aeruginosa* biofilm and planktonic cells in which the biofilm was infected with 4 doses of bacteriophage (10^{10}) suspended in 10ml of tobramycin at the minimal inhibition concentration (4 mg L^{-1}).

10 **Example 1 - Operation of a Chemostat and Robbins Device for Continuous Culture of *Pseudomonas aeruginosa* for Biofilm Investigation**

The present invention allows the isolation and characterisation of bacteriophage that are able to lyse clinical *Ps. aeruginosa* isolates. Bacteriophage are characterised with

15 regard to their potential virulence based on assessment of host range, burst size and efficiency of lysis. The ability of selected phage to lyse sensitive host strains in sputum samples is evaluated and these phage evaluated further in an *in vitro* biofilm model simulating infection with mucoid and non-mucoid strains.

20 The present invention preferably relates to specific bacteriophage, which offer the potential to control *Ps. aeruginosa* induced biofilm formation and, in particular, biofilms involving the more aggressive drug resistant bacterial species that contribute significantly to morbidity and mortality in CF patients.

25 **Background**

A chemostat system has been developed to generate continuous *Pseudomonas aeruginosa* culture. The culture provide inocula for biofilm studies using a Robbins device.

30 The chemostat vessel consists of a 2-litre glass vessel with titanium top plates. The plate is fitted with various probes (pH, temperature and Redox) which allow the physical parameters within the vessel to be monitored and maintained under defined

controlled conditions. A FT Applikon fermenter controller regulates these environmental conditions.

A Robbins device is used to study biofilm formation. The device provides quantifiable

5 samples of biofilms growing on submerged surfaces in an aqueous environment which can be monitored over a time course. It consists of a hollow rectangular acrylic tube with twenty five evenly spaced sampling ports. Each port allows insertion of a sampling stud that contains a polyvinyl chloride (PVC) disk that lies flush to the upper surface of the lumen. The continuous culture is pumped through the Robbins device

10 and biofilms are formed on the surface of PVC disks exposed to the culture. A series of Robbins devices may be run in each experiment. This allows the evaluation of different regimes to reduce biofilm development under identical controlled conditions.

1. Components of the Culture System

15 * ACDP class III microbiological safety cabinet

* Two litre glass chemostat vessel with a titanium top plate housed within the category III cabinet

* Stirrer housed within the class III microbiological safety cabinet

20 * Robbins Device (s) fastened to a Robbins device heater (Anglicon) housed within the class III microbiological safety cabinet

* 20 litre glass medium reservoir housed outside the class III microbiological safety cabinet

* 5 litre glass main effluent reservoir housed within the class III microbiological safety

25 cabinet

* 1 litre glass effluent reservoirs connected to individual Robbins devices housed within the class III microbiological safety cabinet

* Glass alkaline reservoir housed outside the class III microbiological safety cabinet

* Applikon controller unit housed outside the class III microbiological safety cabinet

30 (pH, temperature and Redox probes fitted within the chemostat)

* Stand-alone personal computer housed outside the class III microbiological safety cabinet

2. Operation and Monitoring of the Chemostat

i. A 10-ml aliquot of an 18 hour culture of *Pseudomonas aeruginosa*, at approximately 108 cfu per ml, was used to inoculate the sterile growth media within the chemostat.

5 The inocula was introduced into the chemostat through the sample port in the top plate.

ii. Following inoculation, the chemostat was operated as a batch culture for 4 h to allow establishment of the culture.

iii. Medium addition ($\frac{1}{2}$ strength nutrient broth, Oxoid) was commenced at the desired

10 flow rate (1 ml per min) and the effluent pump was activated. The flow rate of the effluent pump was the same as the inflow pump. The effluent tubing bypassed the Robbins devices leading straight to the main waste reservoir.

iv. The continuous chemostat was run for a predetermined time until a steady state was attained (96-hours). At this stage, the tubes leading to the Robbins devices were

15 positioned onto the multi-head pump, thus instigating culture flow through the Robbins devices.

v. Planktonic culture samples (<5 ml) were removed from the chemostat daily for verification of pH and total viable counts, using a hand held vacuum pump connected to a sample port universal container.

20 vi. The area around the apparatus was checked twice daily (morning and afternoon) for spillage, and the vessel and tubing examined for leaks or splits.

vii. The medium, effluent and culture volumes were recorded on the run sheet and the flow rates calculated accordingly. The volume in the alkali reservoir was also recorded.

25

3. Robbins Device

Upstream of each Robbins device inlet tubes have a 'Y' junction. One line was designated as an inlet port (Port A) and is connected either to the chemostat or a

30 sterile media reservoir. The other line was an inoculation port (Port B) that allowed the inoculation of the Robbins lumen with test agents.

Outlet tubes downstream of the Robbins device also have a 'Y' junction. One line was designated waste and led to a Robbins device waste reservoir (Port C). The other

line led to a sterile universal container (UC) and was used to collect planktonic samples from the Robbins device lumen (Port D).

During initial biofilm development, the inoculation and planktonic sample ports were

5 clamped (ports B and D) and the inlet line (A) was connected to the chemostat.

(i) Steady state culture was flowed through the Robbins device at 1 ml per min for a set time (24-hours) to allow the establishment of a biofilm on the PVC disks. At this time point, the multi-head pump was switched off, culture inlet tubing clamped and

10 subsequently disconnected from the Robbins device at port A.

(ii) Tubing leading from the sterile growth media tubing was then connected to the Robbins device inlet port (A). The clamp on the media tubing was removed and the multi-head pump turned back on and allowed to run until the culture in the Robbins device lumen was replaced with $\frac{1}{2}$ strength nutrient broth.

15

At this time point, studs (x 3) were removed from the Robbins to enumerate biofilm density.

(iii) The multi-head pump was turned off and the inlet and outlet tubing clamped.

20 (iv) A stud was gently removed from Robbins device port and replaced with a sterile stud.

(v) The PVC coupon was carefully detached from the stud by unscrewing the retaining screw.

(vi) Holding the coupon with forceps, the under side of the coupon was rinsed in 1 ml
25 sterile phosphate buffered saline (PBS) to remove loosely adhered cells.

(vii) The coupon was placed in 1 ml PBS contained in a eppendorf, sonicated for 3 min at 60 W, then vortex mixed for 2 min to disrupt the biofilm.

(viii) The coupon was aseptically removed to 5% sodium hypochlorite and the suspension serially diluted in sterile PBS up to 10⁻⁸.

30 (ix) The total viable count (cfu) of the biofilm population was determined using the method of Miles and Misra on tryptone soya agar (TSA).

The biofilm was then infected with bacteriophage / tobramycin or both simultaneously.

- (x) With the media inlet port clamped (A), a 20 ml syringe containing 10 ml of bacteriophage at 10^9 pfu per ml (or tobramycin) was aseptically connected to the inoculation port (B).
- 5 (xi) The clamp was removed from the inoculation port (B) and the planktonic sample outlet port (D), and the bacteriophage suspension / tobramycin solution injected into the Robbins device lumen.
- 10 (xii) Inoculation (B) and planktonic (D) ports were re-clamped and the device was left for 20 min to allow phage infection/tobramycin absorption of the biofilm.
- (xiii) Following 20 min, the media inlet and waste reservoir clamps were released and the multi-head pump started to re-initiating flow of sterile media.
- 15 At predetermined time intervals (1h, 2h, 4h, 6h, 8h, 12h, 18h, 24h and 48h) studs were removed from the Robbins device and replaced with sterile studs as stated in process iii - iv. Coupons were detached from the studs, sonicated and vortex mixed to remove biofilm as in process v - vii. Planktonic and biofilm associated bacteria and phage were then enumerated as stated below:
- 20 (xiv) The coupon was aseptically removed from the suspension to 5% sodium hypochlorite. An aliquot (250 μ l) of the suspension was taken for centrifugation (13000 rpm for 5 min) and the supernatant, containing phage, serially diluted to 10^{-8} . Phage titre was then determined using agar overlay plates with the corresponding host strain (section 4).
- 25 (xv) To the remaining suspension (750 μ l), an adequate volume of ferrous ammonium sulphate (FAS) was introduced in order to achieve a 10 mM concentration and left for 10 min. This compound neutralises the free phage particles in the suspension, without effecting bacterial viability. The suspension was then serially diluted in sterile PBS up to 10^{-8} .
- 30 (xvi) The total viable count (cfu) of the bacterial biofilm population was then determined using the method of Miles and Misra on tryptone soya agar.

4. Calculation of bacteriophage titre

Bacteriophage titre was calculated using an agar overlay infection with exponentially grown *Ps. aeruginosa*.

5

Preparation of log phase culture

- (i) A test *Ps. aeruginosa* strain was streaked out onto a fresh TSA plate from a storage slope and incubated overnight (18 h) at 37°C.
- (ii) Following incubation, the test *Ps. aeruginosa* strain (2-3 isolated colonies) was inoculated into 100 ml tryptone soya broth and incubated for 4 h at 37°C with orbital aeration.

Agar overlay method

- 15 (v) Soft agar, which had been prepared earlier, was re-melted and allowed to cool in a water bath set at 45°C.
- (vi) Sterile tubes (12 mm diameter) were placed in a heating block set at 45°C and left to acclimatise for 10 min.
- (vii) Aliquots (2.5 ml) of soft agar were pipetted into each tube, followed by 500 µl of the 4 hour *Ps. aeruginosa* suspension and 100 µl of the serially diluted phage preparation. Controls were also prepared which contained soft agar only and soft agar and bacteria.
- (viii) The suspensions were mixed then poured over pre-dried TSA plates. The plates were rocked gently to ensure a uniform layer of suspension, then left to dry on a level surface (20 mins). Once dried, the plates were incubated for 18 h at 37°C.

Following incubation, plates were then examined and the number of plaque forming units per ml recorded (pfu per ml).

30 5. Summary of Results

Biofilms of mucoid *Ps. aeruginosa* developed using a Robbins device were shown to be degraded by the administration of alg L carrying phage. Figures 1 and 2 show the effect of single (10-10 pfu per ml) and multiple doses (4 x 10-10 pfu per ml) of

bacteriophage FGH4 on *Ps. aeruginosa* GH56 biofilms over a 24 hour period, which resulted in one and three Log reductions in biofilm populations respectively.

A series of multiple dose experiments were performed to compare the efficacy of

5 biofilm removal with phage against tobramycin, a front line aminoglycoside antibiotic used to treat CF patients. Resultant data showed that four applications at the minimal inhibition concentration (MIC) over a 24 hour period had no significant effect on the *Ps. aeruginosa* sessile population (Figure 3). This experiment was repeated with tobramycin at 10 x MIC and again had no significant effect on biofilm viability.

10

A combined regime of phage ΦGH4 and tobramycin at the MIC level (Figure 4) indicated a three-log reduction in biofilm cells, accompanied by a significant decrease in viability of released biofilm cells. Cells released through the action of phage disrupting the biofilm become susceptible to antibiotic activity.

15

RESULTS

A) Isolation of lytic bacteriophage against clinical *Ps. aeruginosa* strains:

Clinical samples were collected from Liverpool Medical School and screened against
20 our 22 clinical *Ps. aeruginosa* strains and two control strains (NCTC 6750, ATCC 27853). A further 9 lytic bacteriophage were obtained from this study thus bringing the current phage collection to twenty. All isolated phage were enriched against their corresponding host and subsequently stored at 4°C and -70°C.

25 B) Alginate lysis:

At least three of the phage in the collection appeared to exhibit putative alginase activity. Using a turbidimetric procedure developed by Kitamikado *et al.* (1990) we have confirmed that these phage mediate the production of alginate lyase during the
30 lytic cycle. The enzyme is present in phage induced cell lysates but is not found in uninfected cell lysates or in purified phage preparations.

C) *In vitro* biofilm model:

Biofilms of mucoid *Ps. aeruginosa* developed using a Robbins device were shown to be degraded by the administration of phage. Figures 1 and 2 show the effect of 5 single (10^{10} pfu ml $^{-1}$) and multiple doses (4×10^{10} pfu ml $^{-1}$) of bacteriophage Φ GH4 on *Ps. aeruginosa* GH56 biofilms over a 48 hour period, which resulted in one and three log reductions in biofilm populations respectively.

A series of multiple dose experiments were performed to compare the efficacy of 10 biofilm removal with phage against tobramycin, a front line aminoglycosidic antibiotic used to treat CF patients. Resultant data showed that four applications of minimal inhibition concentration (MIC) and 10 x MIC Tobramycin over a 48 hour period had no significant effect on the *Ps. aeruginosa* sessile population.

15 When a dual infection regime of Φ GH4 and MIC tobramycin was tested a three-log reduction in biofilm cells was accompanied by a significant decrease in viability of released biofilm cells (i.e. *Ps. aeruginosa* cells released from the biofilm through the action of phage breaking open the biofilm).

20 D) Stability and lytic activity of phage in sputum:

To ensure effective treatment of cystic fibrosis pulmonary *Ps. aeruginosa* infections bacteriophage should exhibit lytic activity in the viscid sputum/mucin rich environment of the CF lung. *In vitro* phage infection assay performed with mucoid *Ps. aeruginosa* 25 GH56 and phage Φ GH4 in sputum (free of indigenous *Ps. aeruginosa*) recovered from CF patients showed that the phage remains stable and retains greater than 90% lytic activity. Similar results were obtained with lytic infections performed in 5% mucin.

30 E) Stability and lytic activity of phage following aerosolisation:

Delivery of phage to the CF lung preferably takes the form of a non-invasive inhalation system. Phage should therefore retain viability following aerosolisation. A Colison nebuliser coupled to a Henderson Apparatus was used to aerosolise a

specific volume of a known titre of phage Φ GH4. This process generates aerosols in the region of 4 mm which are the optimum size for successful transportation to the alveoli at the base of the lungs. Resultant aerosols were collected, quantified and tested for lytic activity against *Ps. aeruginosa* GH56. Results showed that less than 5 5% of the phage were lost due to aerosolisation and that the phage retained >90% lytic activity against *P. aeruginosa* GH56 following passage through the Henderson Apparatus/Collison nebuliser.

DISCUSSION

10

Twenty phage have been isolated from the environment and clinical specimens. The phage lyse clinical *Ps. aeruginosa* strains, which strains exhibit different host ranges.

15 Exopolysaccharide (EPS) normally protect bacterial biofilm cells against the majority of bacteriophage (Weiner *et al.*, 1995). In the case of *Ps. aeruginosa* pulmonary infections, the bacterial biofilm is encapsulated within a thick alginate matrix. At least three of the phage we have isolated exhibit polysaccharide depolymerase (alginase) activity against a specific *Ps. aeruginosa* alginate. This is important in treating such infections, as the phage may illicit a two pronged attack on mucoid *Ps. aeruginosa* 20 biofilms in degrading its way through the biofilm alginate thus gaining access to the underlying susceptible bacteria. The turbidimetric alginase assay confirms that the enzyme is only present during the lytic cycle of phage infection, and we have confirmed that the alginase activity is phage encoded.

25 Figure 1 shows the effect of one dose of bacteriophage Φ GH4 on an established 24 hour *Ps. aeruginosa* GH 56 biofilm in the *in vitro* biofilm model. The results indicate that a single dose of phage caused a 1 log reduction in biofilm associated *Ps. aeruginosa*. The numbers of biofilm associated *Ps. aeruginosa* however began to rise following 6 hours infection with phage. The rate of growth of biofilm *Ps. aeruginosa* 30 at this time was similar to the control model. We hypothesised that this phenomenon could possibly be caused by washout of the phage from the biofilm (i.e. biofilm rupture resulting in the release of phage into the planktonic phase). To reduce the likelihood of phage washout, it was decided to investigate the effect of multiple doses of phage (4 doses at six hour intervals for the first 18 hours of the experiment) on the

Ps. aeruginosa biofilm (Figure 2). Initial phage infection reduced the biofilm community by 1 log. A further 1.75 log reduction was achieved when the second dose of phage was administered.

5 Of great interest are the results obtained with dual therapy of bacteriophage and tobramycin. We hypothesised that removal of *Ps. aeruginosa* cells from the alginate rich biofilm environment renders the previously resistant cells sensitive to tobramycin. This infection regime therefore generates a synergistic effect on *Ps. aeruginosa* both within the biofilm and bacilli released from the biofilm through the action of alginate
10 lyase phage.

The observation that phage infection and cell lysis was not inhibited in the presence of sputum or by the process of aerosolisation demonstrates that the inhalation conveyance system of phage aerosols would ensure delivery of viable lytic phage
15 into the sputum rich lung alveoli of CF patients.

Example 2 - preparation of a bacteriophage containing a heterologous polysaccharide depolymerase/lyase

20 Method for the insertion of a heterologous alginase gene into a bacteriophage.

(i) Determine the DNA sequence of the entire bacteriophage genome. This is achieved by partial digestion of the bacteriophage DNA with a restriction enzyme that cuts frequently. Frequent cutters are usually those that recognise tetrameric restriction sites. The partially digested DNA is size fractionated on an agarose gel and fragments of 500 to 2000 bp then cloned into a suitable plasmid vector such as pUC18, transformed into an *E.coli* host
25 and grown on selective media. Individual colonies are isolated and the plasmid DNA recovered for DNA sequencing of the bacteriophage DNA fragment carried. Sequencing of clones is continued until a continuous DNA sequence map has been compiled. Any sequence gaps that persist can be closed by chromosome walking ie using primers designed to bacteriophage DNA sequence close to the gaps, identifying clones that contain that
30

sequence by probing and then using that primer in the DNA sequencing reaction.

- 5 (ii) Annotate the genome sequence to identify open reading frames (orfs) and associated promoters/termination sites. Programmes are available either on the internet eg ORF finder or in the DNAsstar suite of programmes which identify open reading frames and enable putative identification of function by comparison with DNA sequence databases.
- 10 (iii) Create a physical map to identify restriction sites suitable for cloning in the alginase gene. DNA sequence data enables the identification of every known restriction site for which there is a restriction enzyme available within the DNA sequence. Physical maps illustrating the position of every restriction site can be created in programmes such as MapDraw from the DNAsstar suite of programmes. Taken together with the annotation of the DNA sequence, regions can be identified which contain useful restriction sites but do not contain ORFs and are therefore less likely to interfere with bacteriophage propagation.
- 15
- 20 (iv) Identify heterologous alginase gene from selected bacteria or bacteriophage for cloning into therapeutic bacteriophage. The alginase gene may be cloned using one of two methods. Direct cloning by PCR using primers designed to the DNA sequence of regions upstream and downstream of the gene of interest. The primers can also contain restriction sites at their 5' ends to facilitate cloning. To ensure the cloning of an active gene product using this method a proof-reading DNA polymerase and a suitable assay for alginase activity should be employed. The second method is to make a gene library of the selected bacteria or bacteriophage containing the alginase in a plasmid such as pUC19 in *E.coli*. The clone containing the active alginase can then be selected by screening for activity.
- 25
- 30 (v) Clone the alginase gene in to each useful site in the bacteriophage DNA *in vitro* and transform in to the host using a suitable procedure which may be transformation, conjugation or electroporation. Useful sites do not necessarily

have to be unique as it is possible to partially digest with a restriction enzyme such that not all the restriction sites are cut.

5 (vi) Confirm bacteriophage retain viability as evidenced by the ability to form plaques.

10 (vii) Screen phage induced cell lysates for evidence of expression of recombinant alginase activity.

15 (viii) Alternatively a marker can be used (lac or GFP for example) if checking for the additional alginase activity is not straight forward.

 (ix) If no suitable unique site is found an appropriate site may be created using site directed mutagenesis based on a PCR approach.

Example 3 - to confirm that a given bacteriophage is capable of infecting a bacterium identified within a biofilm.

20 Isolation of *Pseudomonas aeruginosa* and *Burkholderia cepacia* from clinical samples

25 (i) Aliquots (100 µl) of the clinical sample (e.g. sputum, pulmonary lavage) are spread onto tryptone soya agar (TSA, Oxoid), Pseudomonas CN agar (Oxoid, selective for *P. aeruginosa*), Pseudomonas CFC (Oxoid, selective for *Pseudomonas* species) and *Pseudomonas cepacia* agar (Oxoid, selective for *Burkholderia cepacia*), and allowed to dry for 10 min.

30 (ii) TSA and Pseudomonas CN agar plates are incubated at 37°C for 24 h. If no growth is recorded, plates are incubated for a further 24 h (48 h total incubation).

 (iii) Pseudomonas CFC plates and *P. cepacia* plates are incubated at 30°C and examined after 24 h, 48 h and if necessary 72 h incubation.

Any growth on Pseudomonas CFC medium indicates the presence of *Pseudomonas* spp. The presence of blue/green or brown pigmentation may be taken as presumptive evidence of *P. aeruginosa*.

5 Growth on Pseudomonas CN medium indicates presence of *P. aeruginosa*.

B. cepacia typically grows as smooth, glistening red/purple colonies of approximately 2 mm diameter on *P. cepacia* media. Specific strains may grow as atypical forms including lipopolysaccharide deficient strains with dwarf, rough colonial appearance and

10 a diffusible brown melanin-like pigmentation.

(iv) Isolated colonies are plated onto TSA and the original selective media, then incubated at 37°C (or 30°C depending on the isolation media) for conformation of purity. Once purity is confirmed, the test isolate is inoculated onto a TSA slope and stored at 4°C.

15 Our collection of bacteriophage can now be examined for lytic activity against the test isolate using the agar overlay method.

20 Preparation of log phase culture

(v) The test isolate is streaked out onto a fresh TSA plate from a storage slope and incubated overnight (18 h) at 37°C.

25 (vi) Following incubation, the test strain (2-3 isolated colonies) is inoculated into 100 ml tryptone soya broth and incubated for 4 h at 37°C with orbital aeration.

Agar overlay method

30 (vii) Soft agar, which has been prepared earlier, is re-melted and allowed to cool in a water bath set at 45°C.

(viii) Sterile tubes are placed in a heating block set at 45°C, and left to acclimatise for 10 min.

(ix) Aliquots (2.5 ml) of soft agar are pipetted into each tube, followed by 500 µl of the 4 h test suspension and 100 µl of our serially diluted phage preparation. Controls are also prepared which contain soft agar only and soft agar and bacteria.

5

(x) The suspensions are gently vortex mixed, then poured over pre-dried TSA plates. The plates are rocked gently to ensure a uniform layer of suspension, then left to dry on a level surface (20 mins). Once dried, the plates are incubated for 18 h at 37°C.

10

Following incubation, plates are then examined for lysis, and the number of plaque forming units per ml recorded (pfu ml⁻¹).

15 **Example 4 - to confirm that a given polysaccharide depolymerase or lyase is capable of degrading a biofilm component**

Isolation of biofilm alginate

20 Bacterial constituents of the biofilm must firstly be isolated as a pure culture (see Example 3; Isolation of *Pseudomonas aeruginosa* and *Burkholderia cepacia* from clinical samples).

25 (i) The test isolate is streaked out onto a fresh tryptone soya agar (TSA) plate from a storage slope and sealed. The plate is then incubated for 48 h at 37°C.

(ii) Following incubation, the resulting mucoid growth is removed from the surface using a sterile glass spreader, and suspended in sterile distilled water.

30 (iii) The suspension is vortex mixed, then centrifuged (13000 rpm) for 1 h at 4°C.

(iv) The alginate containing supernatant is then decanted into a sterile tube. Three volumes of absolute alcohol (v/v) are added to the supernatant and left to stand at 4°C for 45 min, thus allowing the alcohol to precipitate the exopolysaccharide.

- (v) The suspension is then centrifuged 5000 rpm for 10 min, and the precipitated exopolysaccharide re-suspended in sterile distilled water producing a viscous solution.
- 5 Our test alginate lyase preparation / bacteriophage carrying alginate lyase is then examined for its ability to lyse clinically isolated alginate using the turbidimetric procedure developed by Kitamikado *et al.* (1990).

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Claims

1. A composition for treating a bacterial biofilm, comprising a bacteriophage that is capable of infecting a bacterium within said biofilm, and a first polysaccharide depolymerase or lyase enzyme that is capable of degrading a polysaccharide within said biofilm.
5
2. A composition according to Claim 1, further comprising an antibiotic.
- 10 3. A composition according to Claim 1 or Claim 2, further comprising a DNase or a polypeptide defensin.
- 15 4. A composition according to any preceding claim, further comprising a second polysaccharide depolymerase or lyase, wherein the first and second polysaccharide depolymerase or lyase are different.
5. A composition according to any preceding claim, wherein the first polysaccharide depolymerase or lyase is encoded by the bacteriophage.
- 20 6. A composition according to any previous claim, wherein the bacteriophage encodes one or more of the antibiotic, DNase, polypeptide defensin, or second polysaccharide depolymerase or lyase enzyme.
- 25 7. A composition according to any previous claim, comprising a second bacteriophage, optionally encoding said second polysaccharide depolymerase or lyase.
8. A composition according to any previous claim, wherein the biofilm is a lung biofilm.
- 30 9. A composition according to Claim 6, wherein the biofilm comprises an opportunistic bacterium, preferably *Pseudomonas aeruginosa* and/or *Burkholderia cepacia*.

10. A composition according to Claim 8 or 9, wherein the phage is a GH phage, preferably ΦGH4.
11. A composition according to any of Claims 8-10, wherein the first or second polysaccharide depolymerase or lyase is an alginate lyase.
5
12. Use of a composition according to any previous claim in manufacture of a medicament for treatment of a biofilm.
- 10 13. Use according to Claim 12, wherein the biofilm is a lung biofilm in a cystic fibrosis patient.
14. Use according to Claim 12 or 13, wherein the medicament is to be administered in more than one separate dose.
15
15. Use according to Claim 14, wherein the medicament is to be administered in at least three separate doses.
16. Use according to any of Claims 12-15, wherein the bacterial cell count of the biofilm is reduced by at least one log.
20
17. Use according to Claim 16, wherein the bacterial cell count of the biofilm is reduced by at least three logs.
- 25 18. Use according to Claim 12 or 13, wherein the medicament is to be administered as part of a combined therapy regimen with one or more of a bacteriophage that is capable of infecting a bacterium within the biofilm, an antibiotic, a polysaccharide depolymerase or lyase, a defensin, and a DNase, wherein said medicament is to be administered prior to, simultaneously with, or subsequent to said bacteriophage, antibiotic, a polysaccharide depolymerase or lyase, defensin or DNase.
30
19. A bacteriophage comprising a heterologous gene encoding a first polysaccharide depolymerase or lyase enzyme.

20. A bacteriophage according to Claim 19, wherein the bacteriophage is capable of infecting a bacterial species or strain present in a biofilm.
- 5 21. A bacteriophage according to Claim 19 or Claim 20, wherein the polysaccharide depolymerase or lyase degrades a polysaccharide component of a biofilm.
- 10 22. A bacteriophage according to any of Claims 19-21 further comprising a second heterologous gene encoding a second polysaccharide depolymerase or lyase enzyme, wherein the first and second polysaccharide depolymerase or lyase are different.
- 15 23. A bacteriophage according to any of Claims 19-22, wherein the bacterial species or strain is an opportunistic bacterium, preferably *Pseudomonas aeruginosa* and/or *Burkholderia cepacia*.
- 20 24. A bacteriophage according to any of Claims 19-23, wherein the depolymerase or lyase enzyme is alginate lyase.
- 25 25. A composition comprising a bacteriophage according to any of Claims 19-24, and one or more additional components selected from an antibiotic, a further polysaccharide depolymerase or lyase enzyme, a DNase, a polypeptide defensin, and a second bacteriophage that is capable of infecting a bacterial species or strain present in a biofilm.
- 30 26. A composition according to Claim 25, comprising first and second bacteriophages according to any of Claims 1-6, wherein the first bacteriophage comprises a gene encoding said first polysaccharide depolymerase or lyase enzyme, and said second bacteriophage comprises a gene encoding a second polysaccharide depolymerase or lyase enzyme, wherein the first and second polysaccharide depolymerase or lyase enzymes are different.

27. A composition according to Claim 25 or 26, further comprising one or more additional bacteriophages according to any of Claims 19-24, wherein said one or more additional bacteriophage encodes a third or subsequent polysaccharide depolymerase or lyase that is optionally different from said first or second depolymerase/lyase, a DNase and/or a defensin.
5
28. Use of a bacteriophage according to any of Claims 19-24 or a composition according to any of Claims 25-27 in manufacture of a medicament for treatment of a biofilm, preferably for treatment of a biofilm that results from an
10 opportunistic bacterial infection.
29. Use of a bacteriophage or composition according to Claim 28, wherein the medicament is to be administered as part of combined therapy regimen with one or more of a bacteriophage that is capable of infecting a bacterium within
15 a biofilm, a polysaccharide depolymerase or lyase, an antibiotic, a defensin, and a DNase, wherein said medicament is to be administered prior to, simultaneously with, or subsequent to said bacteriophage, a polysaccharide depolymerase or lyase, antibiotic, defensin or DNase.
- 20 30. A method of making a modified bacteriophage comprising:
 - a) preparing a biofilm sample;
 - b) identifying an infecting bacterial species or strain within the biofilm;
 - c) selecting at least one gene encoding a polysaccharide depolymerase or lyase enzyme that degrades a polysaccharide within
25 said biofilm;
 - d) selecting or identifying a bacteriophage that is capable of infecting the bacterial species or strain identified in step b); and
 - e) introducing at least one of the genes selected in step c) into the bacteriophage DNA.
- 30 31. A method according to Claim 30, wherein the method additionally comprises the step of testing the efficacy of the modified bacteriophage against the biofilm *in vitro*.

32. A method according to Claim 30 or 31, wherein the bacteriophage specifically infects an opportunistic bacterium, preferably *Pseudomonas aeruginosa* and/or *Burkholderia cepacia*.

5 33. A method according to any of Claims 30-32, wherein said at least one gene encodes an alginate lyase.

10 34. A method of identifying a bacteriophage for use in treatment of a biofilm-associated microbial infection, which comprises:-
a) preparing a biofilm sample;
b) identifying an infecting bacterial species or strain within the biofilm;
c) selecting or identifying a bacteriophage that is capable of infecting said bacterial species or strain and which encodes a polysaccharide depolymerase or lyase that degrades a polysaccharide within said biofilm;
d) optionally testing the efficacy of the bacteriophage against a sample of the biofilm *in vitro*; and
e) if necessary, repeating steps a) to e).

20 35. A method according to Claim 34, wherein the bacteriophage selected in step c) comprises a heterologous gene encoding the polysaccharide depolymerase or lyase.

25 36. A method of treating a biofilm infection, which method comprises:-
administering to a patient a composition according to any of Claims 1-11, a bacteriophage according to any of Claims 19-24, or a composition according to any of Claims 25-27.

30 37. A method according to Claim 36, wherein the composition or bacteriophage is administered in more than one separate dose.

38. A method according to Claim 37, wherein the composition or bacteriophage is administered in at least three separate doses.

39. A method according to any of Claims 36-38, wherein the composition or bacteriophage is administered as an aerosol.
40. A method according to any of Claims 36-39, further comprising the following
5 step:
 - f) administering to the patient one or more of a bacteriophage that is capable of infecting a bacterium within said biofilm, a polysaccharide depolymerase or lyase, an antibiotic, a defensin, or a DNase.
- 10 41. A method according to Claim 40, wherein step g) is carried out prior to, simultaneously with, or subsequent to administration according to any of Claims 36-39.
- 15 42. A method according to any of Claims 36-41, wherein administration is to the site of infection.
43. A method according to any of Claims 36-42, wherein administration is to a surface selected from a lung, a gastrointestinal tract, a catheter, an intravascular device, a prosthetic device, or a dental implant.
- 20 44. An aerosol formulation comprising:-
a composition according to any of Claims 1-11 or 25-27, or a bacteriophage according to any of Claims 19-24; and an excipient, surfactant, and/or propellant.

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Figure 1: Growth dynamics of *Ps. aeruginosa* GH56 and bacteriophage GH4

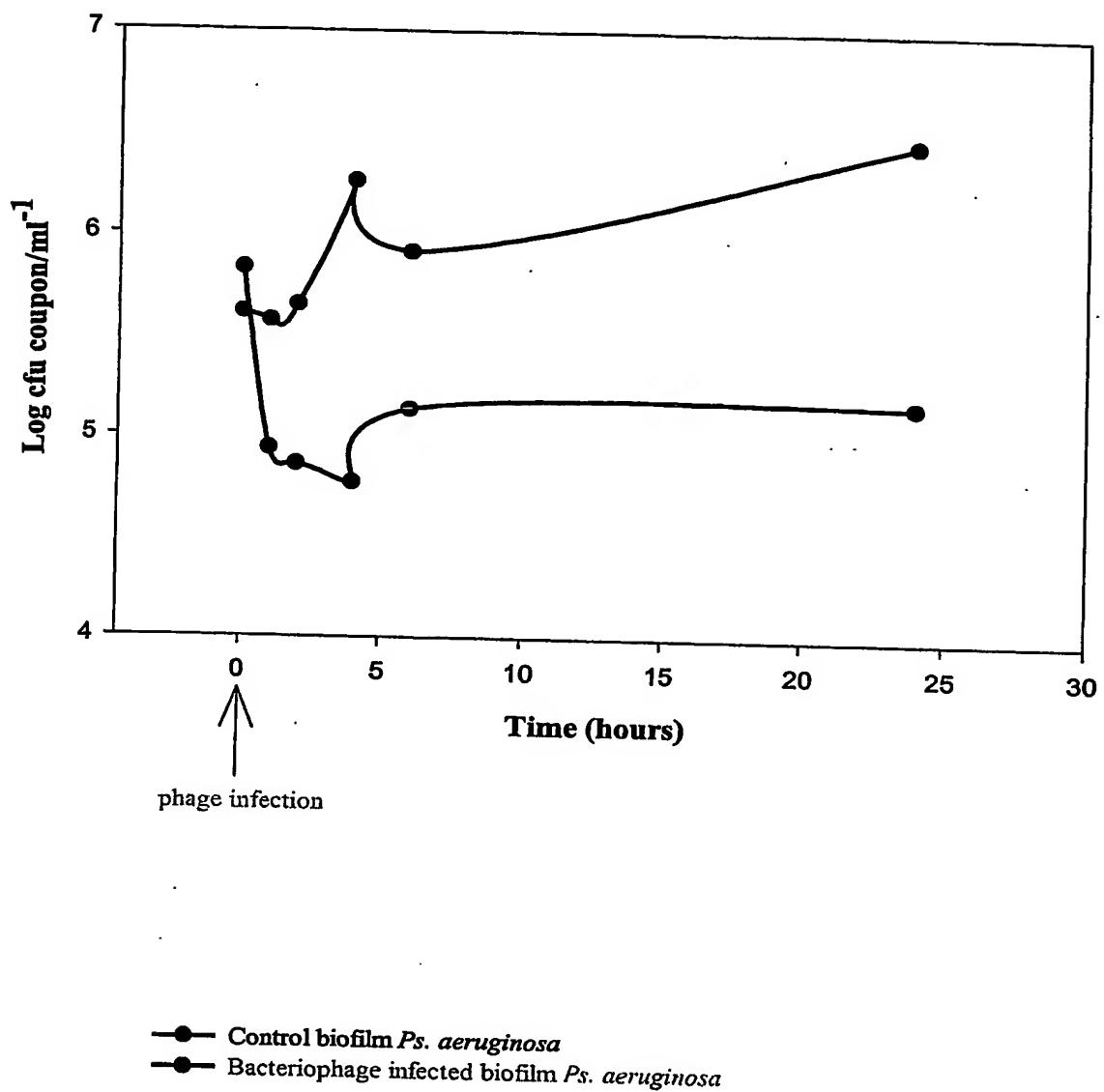
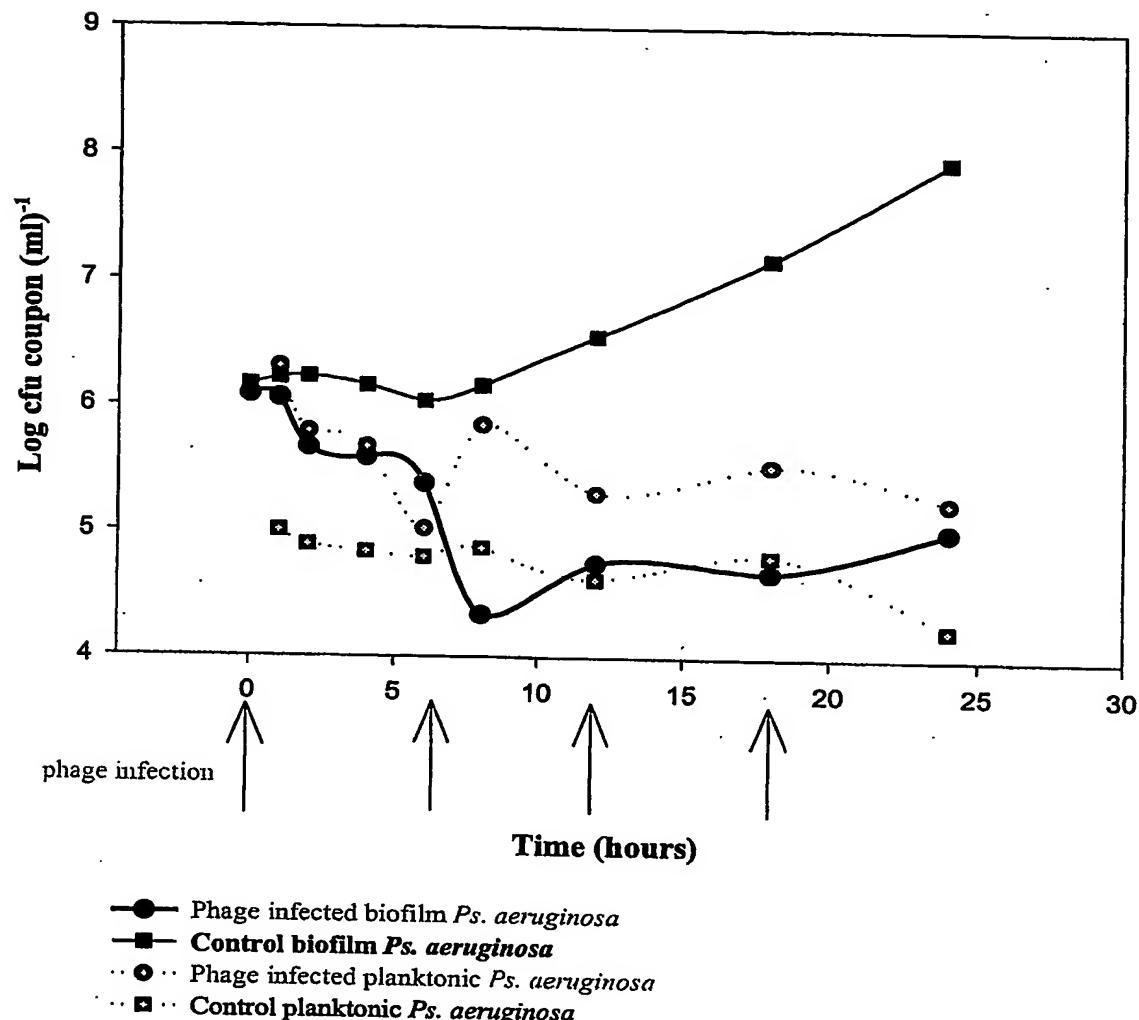


Figure 2 Growth dynamics of phage infected and control *Pseudomonas aeruginosa* GH56



data presented are the mean colony forming units per coupon
(or ml) from triplicate experiments

Figure 3 Mean growth dynamics of control and tobramycin dosed ($4 \times 4\text{mg/L}$) *Ps. aeruginosa* GH56

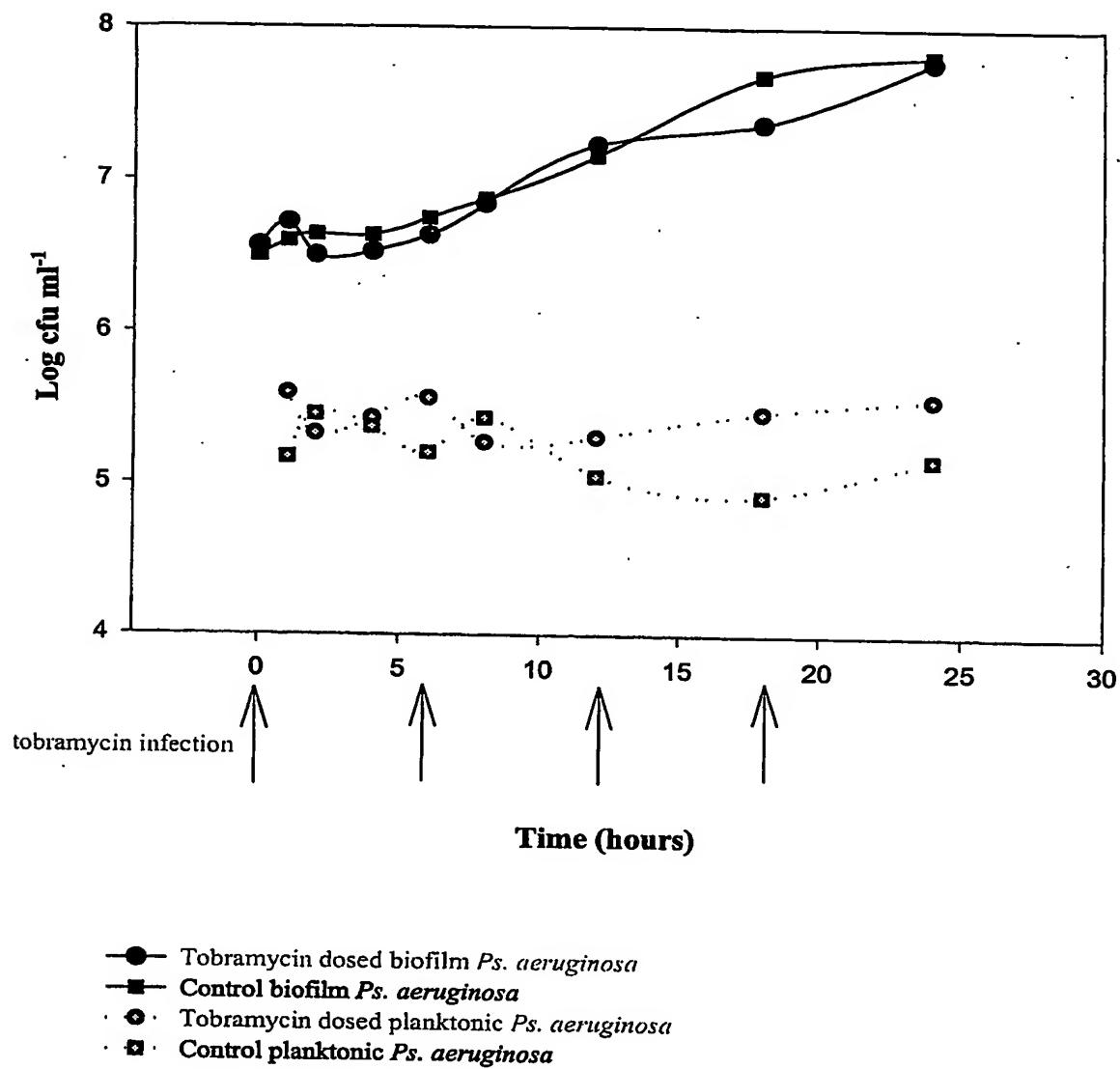


Figure 4 Growth dynamics of control and bacteriophage/tobramycin dosed (4 x 4mg/L) *Ps. aeruginosa* GH56 biofilms

